HEALTH CARE QUALITY WORKING GROUP
PRELIMINARY REPORT
OCTOBER 16, 2000

PREFACE

The Health Care quality working group has been meeting over the past several months amid almost daily news reports concerning the rapidly changing face of our health care system. Recent events surrounding the questionable financial soundness of our health plans, hospitals and nursing homes have given the working group a sense of urgency and a cause for concern. Although we have yet to formally hear from representatives of these sectors, we are concerned about how health care quality for individual consumers and for the community as a whole may be affected by both the scope of these changes, particularly at the hospital level, and the speed at which they seem to be occurring.

Although our work to date has enabled us to conclude that there is no automatic direct correlation between health care spending and quality, and that the efficient allocation of available resources is more apt to have a positive impact on quality than increased spending alone, we are concerned that should spending fall below a certain threshold, minimum safety standards could be compromised.

We have found that a thoughtful examination of the status of health care quality in Massachusetts and its relationship to finance and access is stymied in part by a dearth of relevant comparative information. Indicators, databases and report cards abound, but our ability to drill down to a meaningful level of information is limited. As the following pages indicate, we may know what members think of their health plan, but the public has no way of knowing today "how many nurses are working in the ICU on Tuesday afternoon in a particular hospital" and whether or not that staffing level is adequate to provide good quality care. Consumers should not have to worry about whether staffing levels are adequate for assuring their safety.

It is important to point out that the ground from which we view and address quality is shifting. The recently passed managed care oversight bill creates structures and processes to address certain quality concerns of consumers. Ballot initiative #5, if passed on November 7, would dramatically alter the healthcare landscape including avenues to address quality of care.

The ongoing rapid changes, the urgent financial pressures and the lack of relevant information about a very complex system have contributed to this working group's struggle to report unequivocally on the status of health care quality in our State and how it can be improved. The following pages summarize our work and findings to date and identify the remaining areas for investigation.

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INTRODUCTION

Over the past several months, as the Finance and Access working groups have reviewed the financial conditions in our health insurance market and the extent to which Massachusetts citizens have access to health insurance and medical care, so, too, has the quality working group gathered and reviewed information to ascertain the status of the state's health care quality. The quality working group especially recognizes the interrelatedness of the financing, accessibility and quality of health care and maintains that decisions made in the finance and access realms will have an impact on quality - an issue of common concern throughout this health care system examination.

To date the group has focused on how quality is defined, how it is measured and what efforts now exist to monitor, improve and, ultimately, to assure quality health care to the citizens of the Commonwealth. The group's information sources have consisted of both reviews of the vast literature on the topic and presentations to the group by various stakeholders of the health care system, to date primarily health care purchasers. Although at this writing the group has yet to hear from representatives from all of the major stakeholders; our work has enabled us to make several preliminary findings, which are presented here.

- Quality means different things to different stakeholders at different times and perceptions of quality can sometimes be in direct conflict, but the various dimensions of quality are definable and can be measured to address varying stakeholders' interests

- The usefulness of *current* quality information is highly questionable: provider-specific differences are buried in health plan averages; little is collected from the outpatient setting where increasingly more care is provided; and research has shown that quality information has little impact on consumers', purchasers' or health plans' contracting decisions.

- Massachusetts health plans perform well according to the criteria promulgated by the National Committee on Quality Assurance (NCQA), but the high degree of provider network overlap among Massachusetts' HMOs makes our health plans nearly indistinguishable and comparison among them almost pointless.

- Purchasers' influence on health care quality is limited, in spite of their paying for most of the care.

- The patient, among the major stakeholders, is the most affected by health care quality and yet is the least able to affect it.

- Given the high degree of provider overlap among Massachusetts health plans, the increasing trend in health care delivery to the outpatient setting, and the need for useful, relevant information, the working group finds that a mechanism by which comprehensive provider-level data, including outpatient data, can be collected, coordinated and analyzed in a central uniform way would be useful.

DEFINITION AND DIMENSIONS

Although the Institute of Medicine's definition of health care quality appears to be the most widely accepted,[1] the group found Brandeis University's Jon Chilingerian's multi-dimensional definition of quality[2] to be the most workable for discussion and for providing a framework for developing policy options. Recognizing that the perception of quality differs among the various stakeholders involved, the multi-dimensional model is patient-centered and identifies five underlying dimensions to health care quality: patient satisfaction, information and emotional support, amenities and convenience, decision-making efficiency and outcomes. Chilingerian describes the last two dimensions, decision-making efficiency and outcomes, as the legs of the five points of star quality, which may be the point to begin our focus.

> **Patient Satisfaction** considers patients' overall evaluation of the health care "experience" at every point of contact.
>
> **Information and Emotional Support** refers to efforts to increase or optimize the patient's control and understanding of his or her illness. Portions of this dimension include education and empathy.
>
> **Amenities and Convenience** reflect the patient's preference for technology, people, facilities and behavior.
>
> **Decision-Making Efficiency** focuses on the efficiency of resources used to achieve a satisfactory outcome.
>
> **Outcomes** consider the degree to which the result approaches the fundamental objectives of prolonging life, relieving stress, restoring function and preventing disability.

Surprisingly, a rather dichotomous view of quality can take place between patient and provider. In fact, high patient satisfaction may be correlated with poor medical practices. The over and misuse of antibiotics has been attributed in part to demand by patients who

[1] The Institute of Medicine defines health care quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

[2] Chilingerian, Jon, Chapter 8 "Evaluating Quality Outcomes Against Best Practice: A New Frontier," *The Quality Imperative - Measurement and Management of Quality in Healthcare*, Imperial College Press, 1999.

want medications for conditions that likely do not respond to antibiotics. Another example is requests for cesarean section deliveries by women who have already delivered one child by means of c-section, do not meet criteria for c-section for their next child and yet prefer and request the more invasive and more costly c-section.

QUALITY PROBLEMS

An integral resource for the quality working group has been the Institute of Medicine (IOM) Committee on quality's first report *To Err is Human - Building a Safer Health System*, which focuses on patient safety and the problem of medical errors in the health system. Citing studies conducted in Colorado, Utah and New York, the IOM report estimates that anywhere from 44,000 to 98,000 Americans die each year from medical errors. (Combined deaths per year from motor vehicle accidents, breast cancer and AIDS total less than 98,000 according to the report.) The direct and indirect costs associated with preventable adverse events are tremendous, estimated in the tens of billions of dollars.

It is difficult to estimate the number of Massachusetts residents affected by medical errors without conducting studies similar to those in Colorado, Utah and New York. However, recognizing the importance of patient safety, the Massachusetts Department of Public Health joined with health care providers, regulators and accrediting agencies to form the Coalition for the Prevention of Medical Errors. The Coalition was established as a single forum to focus on system-level practices and to share potential error prevention strategies in the state. Its first initiative focuses on the prevention of medication errors, a significant portion of overall adverse events.
There is general consensus in the medical, academic, and patient advocate communities that quality is compromised of three types of errors: overuse, underuse and misuse of treatments, procedures, and medications.

> **Overuse** is the subjecting of patients to tests, procedures and medications that either cannot help or can cause harm.
>
> **Underuse** refers to the failure to offer patients diagnostic tests and treatments proven to scientifically improve their outcomes.
>
> **Misuse** involves poorly executed tests and procedures and medications that either cannot help or can cause harm.

The tripartite classification of quality problems illuminates the relationship between quality and cost. It also raises questions of whether improving quality leads to increased or decreased costs. Reducing overuse improves quality and reduces cost at the same time. Solving misuse also improves quality and reduces costs. Addressing underuse, however, may improve quality but may also increase costs. The quality working group plans to examine more in depth the impact of finance and access on quality during its future deliberations.

Beginning with its second meeting in May, the quality working group heard several presentations from representatives of Massachusetts's agencies and organizations to learn more about the efforts underway here to measure, monitor and improve health care quality and to begin to identify opportunities for action. Several more presentations are planned. At this writing, the group has heard from:

Howard Koh, M.D., Commissioner, Massachusetts Department of Public Health

Mary Anna Sullivan, M.D., Chairman, Massachusetts Board of Registration in Medicine

Helena Rubenstein and David Czekanski, Group Insurance Commission

Paula Breslin, Executive Director, Massachusetts Healthcare Purchaser Group

Marcy Karcher-Ghirardi, Jerry Cole, Massachusetts Division of Medical Assistance

Roger Gill, Plumbers Union

The working group found the most meaningful and expeditious way to organize and review submitted information and their related findings was by health care system sector (or stakeholder): health plans, providers, purchasers and consumers. Detailed findings by sector follow.

HEALTH PLANS

Current Activities

To date, health care quality measurement and improvement endeavors have targeted two basic areas: health plan performance and provider performance (hospitals and clinicians). The endeavors have been driven largely by purchasers, both private and public, in the quest for "value" for their health care dollars.

The most comprehensive examination of health plans occurs through the NCQA (National Committee on Quality Assurance) accreditation process. Once viewed as providing a marketing edge, accreditation has become a minimum standard for health plans in Massachusetts. Figure 1 (see addendum) compares Massachusetts HMOs with the country by their current NCQA accreditation status, indicating that a much higher percentage of Massachusetts HMOs are rated excellent than HMOs in the rest of the country.

Most quality measurement efforts to date have focused on comparative health plan performance, using **HEDIS** (Health Plan Employer Data & Information Set) measures developed by the NCQA. The fifty-plus HEDIS measures are grouped into seven categories: Effectiveness of Care, Access/Availability of Care, Satisfaction with the Experience of Care, Health Plan Stability, Use of Services, Cost of Care and Descriptive Information. Virtually all health plan measurement efforts across the country use HEDIS

in some way to present comparative data on HMOs, the only differences being which measures are used and who is collecting and presenting the data.

Recognizing the importance of the consumer perspective in evaluating health plan quality, most initiatives presenting HEDIS information also include comparative consumer satisfaction survey information. The **CAHPS** (Consumer Assessment of Health Plans Survey), whose development was sponsored by AHCPR (now AHRQ), has been adopted by NCQA for plans reporting HEDIS data. Selected consumer satisfaction results are usually published along with HEDIS information.

In Massachusetts, the **New England HEDIS Coalition** and the **Massachusetts Healthcare Purchaser Group** (**MHPG**) (of which the **Group Insurance Commission** and the **Division of Medical Assistance** are leading members) are the two organizations involved in the reporting of health plan information. The HEDIS Coalition consists of New England plans and employers who work together to standardize data submissions to NCQA, contract together to have their data audited, and collectively work with NCQA to resolve issues around new measures and data requirements. MHPG reports selected HEDIS information annually in its *Guide to Health Plan Performance*. (*Your Guide to Managed Care in Massachusetts*, published by the Division of Health Care Finance and Policy on behalf of the Governor's Managed Care Advisory Board includes the summary page from the MHPG Guide with their permission.)

Figure 2 (see addendum) presents the MHPG's Summary of Selected HEDIS quality Measures for Massachusetts health plans in 1999. A review of the information indicates that for nearly all of the selected indicators, Massachusetts health plans perform above the national average and the majority of their members have a high overall opinion of their plans.

Working group Concerns

It is very important to note, however, that health plan performance is based upon on data collected from the plans' providers: hospitals and physicians' offices. One of the most glaring difficulties in using health plan performance data is that analysis is limited to the health plan level: differences among reporting providers are lost in the averages. This presents even more of a problem in Massachusetts now that most providers contract with most of the plans.

Given the high degree of provider network overlap among Massachusetts health plans, the working group recognizes the need for quality measurement activities to be directed to the provider level. In addition, because of the multiplicity of provider types and their interrelatedness, the working group also recognizes the need for the establishment of a mechanism by which disparate data can be collected, coordinated and analyzed in a central uniform way.

HEALTH CARE PROVIDERS

Hospitals

Current Activities

Most provider level quality measurement has been done at the hospital level. The national accrediting organization for hospitals is the Joint Commission on Accreditation of Healthcare Organizations (**JCAHO**). JCAHO includes extensive quality assessment in its accreditation process, requiring various performance reporting requirements of hospitals and long term care facilities.

Individual quality improvement efforts based on disease/condition-specific measurement have been launched in many hospitals, sometimes supported by expertise from the **Institute for Healthcare Improvement** (**IHI**) and/or facilitated by hospital associations. HCFA's Peer Review Organizations (PROs) have also become heavily involved in clinical quality measurement and improvement at the local level, including **MassPRO** here in Massachusetts. Public reporting of comparable quality data across hospitals has been limited, however.

Like many other states, Massachusetts collects the Uniform Hospital Discharge Data Set (hospital claims data historically collected for rate setting purposes) and most efforts to compare hospitals to date have involved various analyses of these data. Hospitals have been compared to each other by lengths of stay, average charges, and numbers of procedures, which alone do not present a comprehensive picture of hospital quality. In recent years, methodologies have been developed to analyze readmissions and preventable hospitalizations to get closer to measuring the quality of care delivered both in the hospital and in the pre- and post-acute settings.

Recently, the Agency on Healthcare Research and Quality produced 33 performance measures as part of the "Healthcare Cost and Utilization Project" (HCUP).[3] In Massachusetts, the state Division of Health Care Finance and Policy is collaborating with the Hospital Association to produce hospital-specific HCUP performance measures as a starting point to identify clinical areas that are appropriate for further analyses in our state. However, it is important to note that these analyses are only feasible for a limited number of procedures and that the analyses depend on the completeness and accuracy of data coding.

The **Massachusetts Health Quality Partnership**[4] (**MHQP**) is a "coalition of health, business, and government leaders whose mission is to develop health care performance measurement initiatives to meet public accountability needs, focusing on measurements that result in improvement." Beginning with patient-centered data gathered through validated surveys designed by the **Picker Institute**, MHQP published comparative inpatient care experience information by Massachusetts hospital in late 1998. According

[3] The web site for HCUP is: http://www.ahrq.gov/data/hcup/hcupnet.htm

[4] The web site for MHQP is: http://www.mhqp.org/

to their report, when compared with results from identical surveys conducted for hospitals throughout the country, Massachusetts hospitals consistently reported more favorable results. The most recent attempt at publication, however, has been stalled due to inconsistencies in the survey distribution. MHQP continues to facilitate other data-driven collaborative improvement efforts, including maternity care improvement.

An extensive review of empirical evidence on the impact of quality information was published from 1988 through 1999 and is summarized in an article appearing in the *Journal of the American Medical Association* (JAMA) in April of this year[5] Martin Marshall, et. al., report that hospitals and other provider organizations appear to be more responsive to quality information than other parties, citing significant policy and program changes in response to publicly reported data. The authors refer to a "quasi-experimental design" used to look at hospital behavior in Missouri after publication of an obstetrics consumer report. Half of the hospitals that did not have an infant car seat program, formal transfer arrangements, or breastfeeding nurse educators prior to publication of the report instituted or planned these services after the report was published. Generally, acceptance of the data by institutions seemed to depend on the performance rating, with poor performers more likely to criticize.

Working group Concerns

With the increasing trend to deliver health care in outpatient settings, the working group recognizes that hospital inpatient data, compared to data from other settings, are losing their importance as inpatient care itself becomes less central to the health care delivery system. See section on Outpatient Settings below.

Nursing Homes

Current Activities

At the May 20, quality working group meeting, Commissioner Howard Koh, M.D., presented a summary of the **Massachusetts Department of Public Health's** quality assurance activities, (e.g., licensing providers and providing consumers with information to help them select high quality providers). Dr. Koh described, as an example, the nursing home report card that DPH publishes. The report cards measure quality of care using numerous indicators and are available on the Department's website, www.state.ma.us/dph. Among the nursing home characteristics that are measured are: complaints filed, the necessity for DPH enforcement, staff qualifications, staffing levels and appropriate supervision of staff, safety and cleanliness of facilities, and whether proper care is provided to residents. The Department hopes to conduct a consumer satisfaction survey in the future.

Working group Concerns

[5] Martin, Marshal N. et. al. "The Public Release of Performance Data, What Do We Expect to Gain? A Review of the Evidence," *JAMA*, Vol. 283, No 14, April 2000.

Specific information from Dr. Koh at the working group's October 6 meeting revealed that the number of complaints against nursing homes filed with the Department of Public Health has increased, as has the number of deficiencies cited by DPH's nursing home inspectors. Recent legislation, however, has increased the number of DPH inspectors and Dr. Koh indicated that for the first time, Departmental delays in investigations have been reduced. In addition, new state funding has been made available for the education of nursing home assistants, which should aid in reducing complaints and deficiencies.

Outpatient Settings

Current Activities

The **Massachusetts Health Data Consortium** has collected ambulatory surgery data on a voluntary basis (20 hospitals) for several years, although reporting of the information is limited to the participants. The **Massachusetts Division of Health Care Finance and Policy** now collects and reports on observation stays and intends to collect emergency department data in the future. Analysis of these data to assess quality, however, has yet to be fine-tuned.

Preliminary efforts to collect physician-level data have begun in a few other states, the furthest along being Maryland. Maryland has established an outpatient database and protocols for releasing data to health policy researchers. No definitive plans to do the same in Massachusetts have emerged.

Working group Concerns

Although inpatient care constitutes a substantial portion of health care, it is important to note a significant trend away from hospital inpatient care to outpatient care, particularly in Massachusetts. The necessity for data collection and analysis activities to extend beyond the inpatient setting has become glaringly apparent in recent years, yet initiatives in this area are in their infancy. As indicated in the section "HEALTH PLANS", the working group finds a need for a mechanism for the collection and analysis of outpatient data.

Health Care Professionals

As with health plans, comparing information at the hospital or other delivery site does not allow for discerning differences among the physicians and other health professionals actually making the clinical decisions and delivering the care. In May the **Massachusetts Board of Registration in Medicine** described its activities to the quality working group. The Board was the first in the nation to compile and publicly report physician profiles. Information in a physician profile includes: medical school and training, specialties and board certification, payments made as a result of malpractice suits, criminal convictions and hospital and Board of Medicine disciplinary actions. The Board also administers the Patient Care Assessment (PCA) program, which oversees quality of care at hospitals.

One activity of this program is a requirement that hospitals report their responses to major incidents (unexpected adverse events). Unlike the Department of Public Health, which investigates adverse events immediately, the PCA program conducts its review after the hospital's internal review of the adverse event. The purpose of the PCA program is to promote appropriate hospital responses rather than to discipline individuals. Therefore, the names of individuals involved in adverse events are excluded from PCA reports.

Although Massachusetts has yet to move in this area, some other states, most notably New York and Pennsylvania, have published comparative mortality rates by physician for surgical procedures. Again, according to the JAMA review referred to above, physicians appear to be interested in the data, but skeptical about its use. In a survey of New York's cardiologists' attitudes about published CABG mortality rates, the most common objection was that it might discourage cardiac surgeons from operating on high-risk patients. A similar survey in Pennsylvania revealed a full two thirds reporting "increasing problems finding surgeons to operate on high-risk patients, and the same proportion … reported that they were less willing to operate on such patients."

HEALTH CARE PURCHASERS

Current Activities

As indicated under "**HEALTH PLANS**," the Massachusetts Healthcare Purchaser Group (MHPG) is an active coalition of employers, of which the Group Insurance Commission (GIC) and the state's Division of Medical Assistance (DMA) are leading members. MHPG works with the New England HEDIS Coalition to provide annual comparative health plan quality information to its members.

Working group Concerns

Although the largest health care purchasers in Massachusetts are involved in activities promoting quality at the health plan level, most purchasers have little, if any involvement in this arena. Nearly half of all employees are offered only one health plan, so attempts at distinguishing among plans based on quality becomes useless for this group. The driving motivators for purchasers in choosing which plan(s) to offer to their employees are cost, coverage and choice of provider. The provision of health insurance by employers is still mainly viewed as a benefit to attract employees, with quality defined as a large provider network. Similarly, for employees (before they become patients), the motivators are low out-of- pocket cost, choice of *their* provider and convenience.

The GIC, who presented to the working group, provide comparative information on health plans to their employees. The extent to which it is used in decision-making, however, has not been sufficiently determined. The group learned from its research that the evaluation of the impact of the dissemination of quality information has not kept pace with its growth. Currently, it is difficult to assess with conviction whether the proliferation of health care quality information has had any impact, or will have any impact, on the behavior of the parties involved.

According to the JAMA review cited earlier, *evidence suggests that publicly reported health care information has "only a limited impact on consumer decision making."* Several reasons contribute to consumers' lack of interest and use: " …difficulty in understanding information, disinterest in the nature of the information available, lack of trust of the data, problems with timely access to the information, and lack of choice." The review cites evidence that consumers rate anecdotal evidence from family and friends more highly than empirical evidence.

Regarding purchasers' use, the review concludes from the evidence that public disclosure of health performance data has only a small, although possibly increasing, effect on purchasing behavior. A 1998 survey of large US employers revealed that, although familiarity with NCQA accreditation of health plans had increased over the previous year, only 11% of employers considered it to be very important. Only 1% provided HEDIS data to their employees.

Despite its perceived limited usefulness to date, some evidence suggests that quality reporting, especially comparative, leads providers and health plans to improve. While quality reporting does not seem to heavily influence consumer or employer choice at the moment, it may in the future as content and dissemination methods are revised to make the information more meaningful and useful. In addition, objective reporting may level the competitive playing field among provider institutions, especially where lesser known or lower cost facilities show up as having high quality care.

CONSUMERS

The working group found it instructive to view consumers as not one homogeneous group, but as at least three groups depending on timing and circumstances: employees, health plan members and patients.

The group spent one session examining the motivations, decisions and relationships among the primary stakeholders in the health care system: consumers, purchasers, health plans and providers. (See Figure3) It became clear through this examination that quality was of the highest priority to the consumer at the time of his becoming a patient. *Where purchasers are more motivated by minimizing cost, and health plans motivated by the need to develop wide provider networks to attract more members, it is at the juncture where patient meets provider that the emphasis on health care quality is paramount. It is also where the consumer is the least powerful*. With the balance of medical technical knowledge weighing heavily on the provider side and the dollar leverage in the hands of the health plan rather than the individual patient, consumers' ability to "vote with their feet" is severely limited. The limitation is additionally compounded if as an employee, the consumer had only one choice of health plan.

The opportunity for government to assume more of a role in assuring quality health care and educating consumers becomes apparent at this juncture as well. The imbalance in information and power, and the difference between consumers' desires and good quality care as defined by professional process and/or outcome standards, points to the need to educate consumers so they are better able to distinguish poor from good quality care.

MULTIPLE APPROACHES BY STATE AND NEXT STEPS

The state has several policy approaches available for its use in assuring health care quality for its citizens. These include legislation, regulation, monitoring, data and information aggregation and dissemination, and market influence through its own agencies' health care purchasing policies. (See Figure4)

Several of these approaches, albeit at the health plan level, are contained in the recently enacted state legislation, "An Act Protecting the Health and Safety of Massachusetts Consumers from Certain Managed Care Practices in the Insurance Industry". In addition, the Institute of Medicine, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and the Massachusetts Health Policy Forum's Issue Brief entitled: Medical Errors and Patient Safety in Massachusetts: What is the role of the Commonwealth have promulgated sets of recommendations to improve health care quality. The quality working group will review each of these in concert with its additional information gathering to identify and formulate policy options for Massachusetts.

The working group will also more closely examine the impact of heath care financing and access on quality. Imminent policy choices, especially around financing, will affect quality, and it is important to understand how and to what extent.

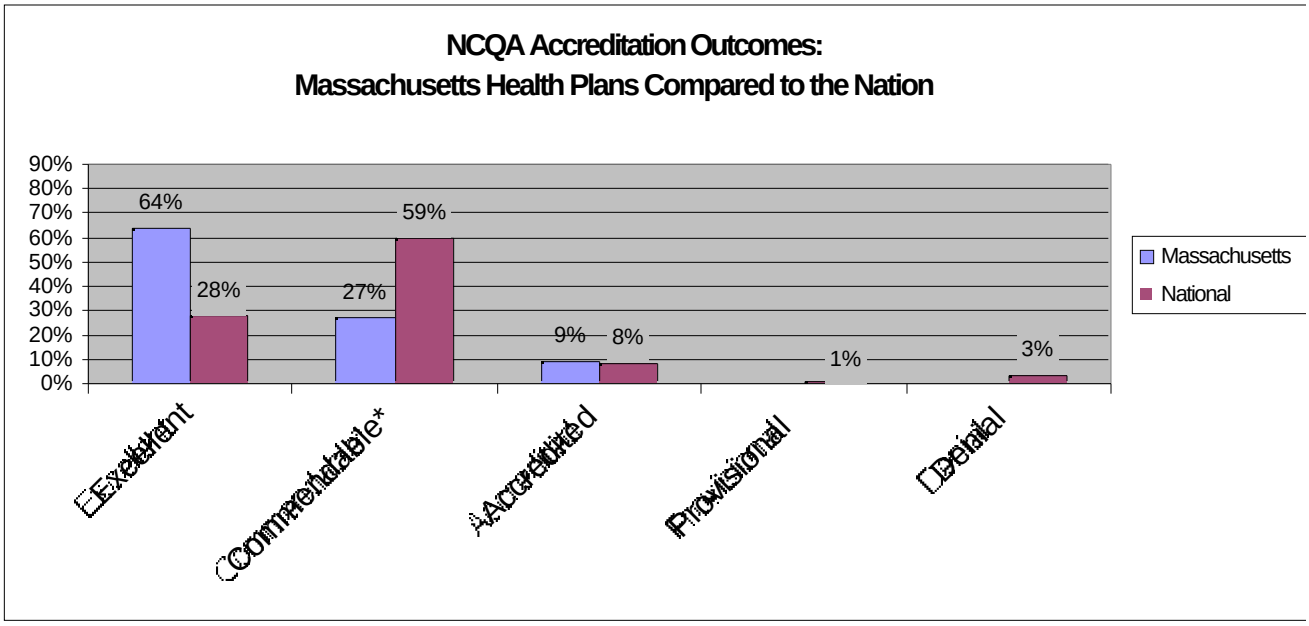
The group will address Mental Health and Substance Abuse in its deliberations as well. Among those remaining to be invited to present to the quality working group are: hospitals and clinicians, health plans, consumers, selected quality and information experts, consumers and possibly accrediting organizations and additional regulators.

Addendum

Figure 1.

NCQA Accreditation Outcomes: Massachusetts Health Plans Compared to the Nation

Accreditation	Massachusetts	National
Excellent	64%	28%
Commendable*	27%	59%
Accredited	9%	8%
Provisional		1%
Denial		3%
TOTAL	100%	100%
	n=11	n=264



Sources:Your Guide to Managed Care in Massachusetts, Massachusetts Managed Care Ombudsman; NCQA's Health Plan Report Card.
See NCQA webpage: http://www.ncqa.org/pages/hprc/index.asp.

Figure 2

Summary of Selected HEDIS Measures	National Average, HMO and POS	# Scoring Above	# Scoring Equal to	# Scoring Below	# Not reporting on Measure	Total
Cervical Cancer Screening	69.8%	10	2	0	1	13
Breast Cancer Screening	72.3%	10	2	0	1	13
Improving Survival after a Heart Attack	79.7%	9*	1	0	3	13
Preventing Blindness for People w/Diabetes	40.6%	10	2	0	1	13
Caring for People w/ Mental Illness	67.4%	2	8	1	2	13
Immunizing Children	61.5%	10	2		1	13
Members Opinions	56.3%	10	0	1	2	13

*Notes: Includes commercial health plans only.

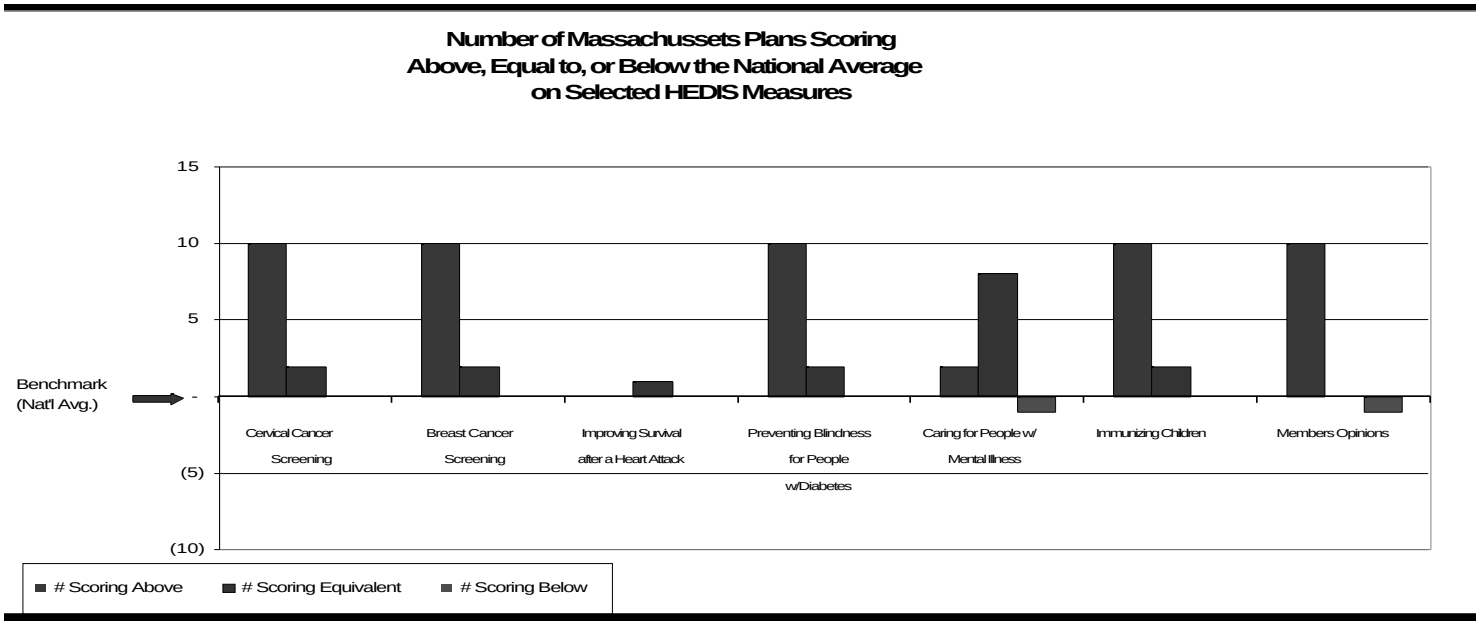
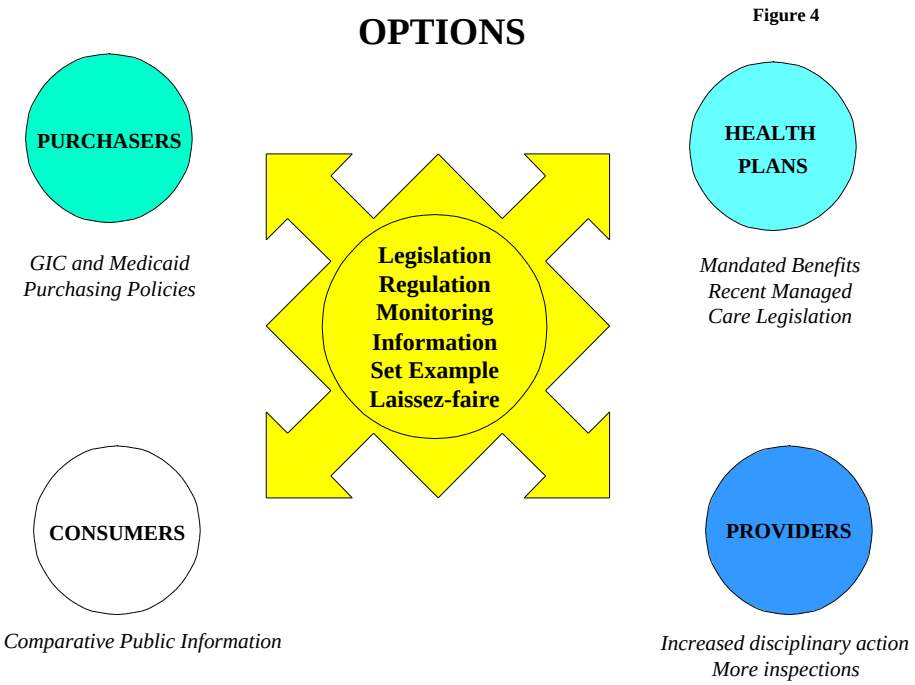


Figure 3


OPTIONS
Figure 4
PURCHASERS
GIC and Medicaid
Purchasing Policies
HEALTH
PLANS
Mandated Benefits
Recent Managed
Care Legislation
Legislation
Regulation
Monitoring
Information
Set Example
Laissez-faire
CONSUMERS
Comparative Public Information
PROVIDERS
Increased disciplinary action
More inspections